2.a.i. Creating an Integrated Delivery System

An Orientation to Project Requirements

Kari Burke, CNY Care Collaborative
Craig Stevens, John Snow, Inc.

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Agenda

- What is an Integrated Delivery System?
- Project Overview
  - Goal and Objectives
  - Description
  - Requirements
  - Timeline
- Discussion
- Next Steps
An Integrated Delivery System…

…is a network of health care providers and organizations which provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population.
The Health Care Delivery System – a journey of transformation

Acute Health Care System 1.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Coordinated Seamless Health Care System 2.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Community Integrated Health Care System 3.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Source: CMS Innovation Center (CMMI)
Goal and Objectives

Eliminate fragmentation and evolve provider compensation and performance management systems to reward providers demonstrating improved patient outcomes

PPS Organizational Structure

System Transformation

Service delivery structure representing continuum of services
Charting the Course

Domain 1: Project Milestones and Metrics (11)
1. Continuum of services represented
2. Increase capacity and improve infrastructure
3. Promote value based care
4. Design patient-centered systems
1. Continuum of services represented

- All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.

- Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.
2. Increase capacity and improve infrastructure

- Achieve 2014 Level 3 PCMH primary care certification for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of Demonstration Year 3 (2017).
- Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year 3 (2017).
- Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3 (2017).
3. Promote value-based care

- Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.
- Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.
- Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.
4. Design patient-centered systems

- Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.
- Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
- Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.
All participating providers will achieve project requirements by Q3/Q4 2018.

<table>
<thead>
<tr>
<th>Project Scale</th>
<th>Total Committed</th>
<th>Number in Network</th>
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</thead>
<tbody>
<tr>
<td>Primary Care Physicians</td>
<td>307</td>
<td>307</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>973</td>
<td>973</td>
</tr>
<tr>
<td>Hospitals</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Clinics</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>16</td>
<td>16</td>
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<tr>
<td>Behavioral Health</td>
<td>106</td>
<td>106</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Skilled Nursing Facilities / Nursing Homes</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Hospice</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>All Other</td>
<td>723</td>
<td>723</td>
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</tbody>
</table>
## DSRIP Payment and Milestones

<table>
<thead>
<tr>
<th>Year</th>
<th>Reporting (%)</th>
<th>Performance (%)</th>
<th>Both (Domain 1: Project progress)</th>
</tr>
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<tbody>
<tr>
<td>Year 1</td>
<td>20%</td>
<td>0%</td>
<td>80%</td>
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<tr>
<td>Year 2</td>
<td>25%</td>
<td>15%</td>
<td>60%</td>
</tr>
<tr>
<td>Year 3</td>
<td>15%</td>
<td>45%</td>
<td>40%</td>
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<tr>
<td>Year 4</td>
<td>15%</td>
<td>65%</td>
<td>20%</td>
</tr>
<tr>
<td>Year 5</td>
<td>15%</td>
<td>85%</td>
<td>0%</td>
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**Domain 2: System Transformation Metrics**

<table>
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<th>Metric</th>
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<tbody>
<tr>
<td>Potentially Avoidable Emergency Room Visits</td>
</tr>
<tr>
<td>Potentially Avoidable Readmissions</td>
</tr>
<tr>
<td>PQI Suite - Composite of all measures</td>
</tr>
<tr>
<td>PDI Suite - Composite of all measures</td>
</tr>
<tr>
<td>CAHPS Measures including usual source of care Patient Loyalty</td>
</tr>
<tr>
<td>(Is doctor/clinic named the place you usually go for care? How long</td>
</tr>
<tr>
<td>have you gone to this doctor/clinic for care?)</td>
</tr>
<tr>
<td>HEDIS Access/Availability of Care; Use of Services</td>
</tr>
<tr>
<td>CAHPS Measures: Getting Care Quickly, Getting Care Needed, Access to</td>
</tr>
<tr>
<td>Information, After Hours Wait Time</td>
</tr>
<tr>
<td>% of total Medicaid provider reimbursement received through sub-</td>
</tr>
<tr>
<td>capitation/other forms of non-FFS reimbursement</td>
</tr>
<tr>
<td>Percent of Eligible Providers with participating agreements with</td>
</tr>
<tr>
<td>RHIO's; meeting MU Criteria and able to participate in bidirectional</td>
</tr>
<tr>
<td>exchange</td>
</tr>
<tr>
<td>Percent of PCP meeting PCMH (NCQA)/ Advance Primary Care (SHIP)</td>
</tr>
<tr>
<td>Medicaid spending on ER and Inpatient Services</td>
</tr>
<tr>
<td>Medicaid spending on PC and community based behavioral health care</td>
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Next Steps

1. Develop Detailed Project Work Plan with SME
2. Post Work Plan to CNYCC Website for Liaison Review
3. Convene Liaisons to Discuss Detailed Project Work Plan (Week of 2/23)
4. Convene Liaisons to Discuss their Organizational Readiness to Implement (Early March)
Readiness Questions

- Who has or will have authority to commit your organization to a specific project implementation schedule, specifically the start and end dates for project implementation?
- When can your organization **commit** to a specific project implementation schedule?
- Is your leadership willing to provide **protected time** for key staff to engage in clinical systems change work?
- Has a systems change team for **any project** with which you are participating been identified?
- Has a systems change team for **all projects** with which you are participating been identified?
Questions & Answers

Kari Burke
burkeka@upstate.edu
(315) 464-9673

Craig Stevens
craig_stevens@jsi.com
(802) 651-7402

Joe Reilly
Joseph.Reilly@sjhsyr.org

Shannon Mathewson, MBA
Director of Operations
Faxton---St. Luke’s Healthcare
smathews@mvnhealth.com

Nicole L. Harmon, MBA, PCMH
CCE
Director, PCMH Advisory Services
HANYS Solutions
NHarmon@hanys.org